STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155228	A. BUILDING _____ B. WING _____	02/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE OF RICHMOND	2070 CHESTER BLVD RICHMOND, IN47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 02/28/11 Facility Number: 000133 Provider Number: 155228 AIM Number: 100266080 Surveyor: Mark Bugni, Life Safety Code Specialist At this Life Safety Code survey, Heritage House of Richmond was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has a capacity of 87 and had a census of 48 at the time of this visit.	K0000	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.Please accept this Plan of Correction as Credible Allegations of Compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 03/04/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following			
K0027 SS=E	Based on observation and interview, the facility failed to ensure 3 of 7 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.6 requires doors in smoke barriers shall comply with Section 8.3.4. LSC 8.3.4.1 requires doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch. This deficient practice could affect 22 residents who reside on the Southeast Hall, 22 residents who reside on the Northwest Hall, and any resident using the restorative therapy room on the West Hall. Findings include: Based on observation on 02/28/11 during a tour of the facility from 10:10 a.m. to 1:00 p.m. with the maintenance supervisor, the Southeast Hall set of smoke barrier doors, the Northwest Hall set of smoke barrier doors, and the West	K0027	It is the practice of the facility that smoke barrier doors will restrict the movement of smoke for at least 20 minutes; shall close the opening leaving only minimum clearance necessary for proper operation which is defined as 1/8 inch.There was no actual harm to any residents.Doors in question were repaired by maintenance man on March 9, 2011.Maintenance will continue to monitor doors monthly when fire drills are done and report to QA.	03/09/2011

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	Hall set of smoke barrier doors each had between a one inch and a two inch gap from the bottom to the center of the doors with the doors in the closed position. This was verified by the maintenance supervisor at the time of observation. 3.1-19(b)			
K0029 SS=E	Based on observation and interview, the facility failed to ensure the corridor door to 3 of 12 hazardous areas, such as combustible storage areas over 50 square feet in size and a fuel fired boiler room, were provided with doors equipped with a self closing device which would cause the doors to automatically close and latch into the door frames. This deficient practice affects any residents using the activity room, and 22 residents who reside on the Northwest Hall. Findings include: Based on observations on 02/28/11 during a tour of the facility from 10:10 a.m. to 1:00 p.m. with the maintenance supervisor, the door to activity storage room one, which measured one hundred twenty seven square feet in size; the door to activity storage room two, which measured one hundred forty seven square	K0029	It is the practice of the facility that combustible storage areas over 50 square feet in size and a fuel fired boiler room, are provided with doors equipped with a self closing device.There was no actual harm to any residents.The 2 activities room doors had self closing devices installed on them by the maintenance man. The northwest boiler room door was already equipped with a self closing device; however, the door did not close properly. The self closing device was adjusted by the maintenance man and is working correctly.Maintenance man will monitor all storage room doors with self closing devices to ensure they are working properly weekly for 1 month, then biweekly for 1 month, then monthly times 3 months and report to QA.	03/30/2011

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	feet, and stored shelves of combustible paper, and combustible cardboard boxes; and the door to the Northwest Hall boiler room, where two gas fired hot water heaters were located, had doors which were not equipped with self closing devices. This was verified by the maintenance supervisor at the time of observations. 3.1-19(b)			
K0038 SS=E	Based on observation and interview, the facility failed to ensure 1 of 7 exit accesses supplied with a delayed egress lock, unlocked upon activation of the fire alarm system. LSC 7.2.1.6.1, allows approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or	K0038	It is the practice of the facility to ensure exit access is arranged so that exits are readily accessible at all times. That exits supplied with a delayed egress lock, unlock upon activation of the fire alarm system.There was no actual harm to any resident.The door in question is not the West Hall exit door it was the East Hall exit door. On 03-01-11 Integrated Electronics was here to repair the door, the power supply was bad, it was removed and replaced.Maintenance man will continue to monitor doors monthly when fire drills are done.	03/01/2011

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	activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. This deficient practice affects any residents using the restorative therapy room and use the West Hall exit during an evacuation. Findings include: Based on observations on 02/28/11 during a test of the fire alarm system at 12:15 p.m. with the maintenance supervisor, the West Hall exit door, which was equipped with a delayed egress lock, failed to magnetically release after the fire alarm system was activated. This was verified by the maintenance supervisor at the time of observation. 3.1-19(b)			

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K0046 SS=F	Based on record review and interview, the facility failed to ensure 2 of 2 corridor battery backup lights were tested at 30 day intervals and annually for a 90 minute duration to ensure the lights would provide lighting during periods of power outages to protect 48 of 48 residents. Section 7.9.3 requires a functional test shall be conducted on every required emergency lighting system at 30 day intervals for not less than 30 seconds. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents in the facility. Findings include: Based on an interview on 02/28/11 at 9:40 a.m. with the maintenance supervisor, the facility has two battery backup lights, one located in the emergency generator location and the other light in the activity room. Based on a review of the Preventive Maintenance Log Book, Fire Drill Reports, and the Monthly Emergency Generator Check & Testing Log with the maintenance supervisor at 9:50 a.m. on 02/28/11, there was no evidence the battery powered backup	K0046	It is the practice of the facility that emergency battery back lighting of least 1 1/2 hours duration is provided in accordance with 7.9There was no actual harm to any resident.The two lights in question were already being tested weekly, however the maintenance man did not log this. On 03-16-11 they were tested and logged by the maintenance man. Lights will continue to be tested monthly for not less than 30 seconds and annually for90 minutes annually this will be logged by the maintenance man.Maintenance man was inserviced on 03-16-11. Administrator or designee will audit log monthly for 6 months then PRN, results will be discussed at QA.	03/16/2011

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	lights are tested at thirty day intervals or annually for a ninety minute duration. This was verified by the maintenance supervisor at the time of record review. 3.1-19(b)			
K0050 SS=F	Based on record review and interview, the facility failed to conduct quarterly fire drills on each shift for 1 of 4 quarters during the past year to protect 48 of 48 residents. This deficient practice affects all residents in the facility. Findings include: Based on a review of Fire Drill Reports with the maintenance supervisor on 02/28/11 at 9:50 a.m., there was no record of a fire drill conducted for the third shift, second quarter of the year 2010. Based on an interview with the maintenance supervisor on 02/28/11 at 10:00 a.m., there was no other documentation available for review to verify a third shift fire drill was conducted for the second quarter of 2010. 3.1-19(b)	K0050	It is the practice of the facility to hold fire drills at unexpected times under varying conditions and at least quarterly on each shift. There was no actual harm to any resident. Maintenance man was inserviced on fire drills and given a schedule for fire drills March 16, 2011. Administrator or designee will audit fire drills monthly for 6 months and report to QA.	03/16/2011

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